



Enterprise Eligibility Progresses

The Enterprise Eligibility Project is the future of ESI eligibility data storage and accessibility. Prior to the creation of the Central Eligibility Database (CED), eligibility data was stored across the enterprise in multiple systems with no link between those systems. By taking the eligibility data stored in those systems and linking that data in the CED, we now have the ability to look at a member's entire experience at ESI.

The Enterprise Eligibility construction story begins back in 2002 with the building of the CED. In 2003, replication of eligibility data from Anchor began. HDS member profile information was added to the CED, as well as disaster recovery and failover capabilities. In 2004, the first data feeds were extracted from the CED. Clinical, ODS, RxHub and HDS previously received an extract from Anchor, and all have more frequent data extracts now coming from the CED. In addition, HDS address validation was implemented in 2004, which resulted in a \$200K annual reduction in returned scripts.

Compass and WEB began looking at the CED eligibility data in 2005. The success of this change was a reduced number of failed Web/IVR log-in attempts, lower MIPS costs, and a reduction in failed patient searches and reduced Compass average handle time (AHT) for lookups involving eligibility services. In addition, member linking was implemented in 2005. Member linking allows members across divisions and services to be identified as one person. For example, the Customer Care Center

can now find mail order and retail information for a member with one search. Previously multiple searches were required.

In 2006, the foundational focus has been on stability, reliability, data validation and reconciliation. Functional enhancements that are being implemented this year include IVR utilizing the CED, the ability for a user to manually link members, leveraging the CED to prevent duplicate profile creation in HDS, and enhancing the HDS processes to use cli-

ent-supplied data to validate member coverage and determine patient eligibility. Keep your eyes out for future enhancements that improve our member experience and reduce costs!

In 2006, the foundational focus has been on stability, reliability, data validation and reconciliation

2005 Enterprise Eligibility Significant Wins:

- CED presents Mail & Retail patient data to Compass users in a single search.
- 5720 additional Web logins per month.
- 6000 additional refills via Web per week
- New search service benefits
 - Member search is lower cost to maintain
 - Improved search accuracy
 - Ensures more consistent patient experience across entry point (Compass & Web)
- Mainframe MIPS savings reduced processing costs
- 92% of patients with Mail & Retail data have been linked allowing a more comprehensive service experience for these patients.

What's Inside

Benefits of a BA	2
AQS Openings	2
RFP Pipeline	3
Team Spotlight	3
Meet Your Co-Worker	4
Liaison Luncheon	4

Medicaid Subrogation Claims

Medicaid Subrogation claims are claims processed and paid by Medicaid as primary payor when in fact, by Medicaid legal requirements, should have been processed and paid by a non-Medicaid insurer. Medicaid legal requirements mandate claim processing of prescription claims under primary payors, as Medicaid is the payor of last resort, thus the term 'subordinate payor.'

Express Scripts has traditionally assisted Medicaid agencies or third party vendors in processing Medicaid subrogation claims either via the paper claim process or via a recently created batch process available for a small number of specific clients.

Until recently ESI has received and processed a manageable volume of subrogation

(continued on page 2)

Benefits of a Business Analyst

What are the benefits of having a Business Services Business Analyst on your project?

The Business Analyst (BA) role grew out of a need to have projects defined at a more detailed level earlier in the project. This helps position the project for high level design, a detailed estimate, and negotiation of which requirements are in scope.

The BA mission is to gather, analyze, document and communicate excellent requirements. The most commonly accepted definition of a BA is that of communicator bridging the gap between the business (the what) and the technical (the how) views of the system. The BA acts as a liaison between all Stakeholders to ensure the requirements developed meet the needs of the business. The BA will capture requirements in approved audit control point documents and ensure stakeholders agree to and sign-off on the requirements.

The specialization of the BA role has advantages for each of the stakeholders:

- The BA will help the Business prioritize requirements so that they may choose how to spend their IT dollars and decide what is in and out of scope. The BA will trace all requirements in scope through the

design and test cases to ensure the requirements developed match the Business needs.

- The Project Manager will be able to focus on the leadership of the project rather than the requirements gathering process.
- The Development Team will be able to create design alternatives based on the business requirements.
- The Quality Assurance Team will be engaged by the BA earlier in the project, allowing more time to interact and focus on the test plan and the creation of test cases.

Contact Matt Bergerson at x377475 if you have questions about the BA role.



BLM IT Picnic August 22: Mike Rosen and Bill McMahon

You may have noticed some changes to the Newsletter this month. The front page has been slightly reformatted, and a new regular feature debuts below.

AQS Open Positions

Director	Hiring Mgr	Position Title	Grade	Posting #	Posted Dte
Markus	Beedle	IT Team Lead	H1	206150603	06/16/06
Markus	Fortier	Engineer	H1		09/05/06
Storey	Bergerson	Sr. Business Analyst	H1		08/30/06
Wales	George, M.	QA Analyst	G1	208090602	08/10/06
Wales	Schmick	QA Team Lead	H1	1008070601	08/08/06
Wales	Wales	QA Manager	I1		09/01/06

Medicaid Subrogation, con't.

(continued from page 1)

claims. Because of tightening state budgets, agencies have been motivated to identify and recoup payments made for Medicaid claims which should have been paid by other insurers.

Specifically, one vendor (HMS) who assists states with Medicaid claim recovery submitted approximately 4 million claims to ESI for processing. (Subsequent research showed that a good percentage of these claims were not related to Express Scripts' client base). As you can imagine, this volume has put a spotlight on the process and has prompted ESI to initiate efforts to manage the volume and processing of Medicaid subrogation claims.

ESI is assisting Medicaid agencies and clients in the subrogation process in a number of ways. Recently, ESI developed a process whereby eligibility files are extracted and delivered to vendors for use in identification of appropriate claims for which the original claims should have processed at ESI as primary. Once claims are identified, then the vendor delivers those claims to ESI for paper or batch processing as appropriate. ESI is also working with CMS to encourage states to move to 'cost avoidance' instead of 'pay and chase' as is practiced today. Cost avoidance is basically online COB, where the Medicaid plan would reject claims submitted as primary when in fact other coverage is available under another insurer. To assist with this effort, ESI has initiated a project to deliver primary or tertiary payor information back to the pharmacy for Medicaid claims where ESI is not the primary payor. This will assist in routing the claim to the appropriate payor, reducing 'pay and chase' situations.

